AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Network Adequacy and Transparency Act is amended by changing Section 10 as follows:

(215 ILCS 124/10)

(Text of Section from P.A. 103-650)

Sec. 10. Network adequacy.

(a) Before issuing, delivering, or renewing a network plan, an issuer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An issuer shall not prohibit a preferred provider from

discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the issuer in accordance with any rights or remedies available under applicable State or federal law.

(b) Before issuing, delivering, or renewing a network plan, an issuer must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers in each plan, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be

rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience

of the preferred providers, as protected by the Health Care Right of Conscience Act, the issuer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a

preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

(c) The issuer shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department for each network plan.

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall

not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; ~~and~~

(CC) HIV; and~~.~~

(DD) Genetic Medicine and Genetic Counseling.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid

Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

(d) The network plan shall demonstrate to the Director maximum travel and distance standards and appointment wait time standards for plan beneficiaries, which shall be established by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the

federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

If the federal area designations for the maximum time or distance or appointment wait time standards required are changed by the most recent Letter to Issuers in the Federally-facilitated Marketplaces, the Department shall post on its website notice of such changes and may amend its rules to conform to those designations if the Director deems appropriate.

(d-5)(1) Every issuer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Issuers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate

access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated

Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), issuers who are not able to comply with the provider ratios and time and distance or appointment wait time standards established under this Act or federal law may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the issuer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii)

provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the issuer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Issuers are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of $5,000 per

day.

(i) If a network plan is inadequate under this Act with respect to a provider type in a county, and if the network plan does not have an approved exception for that provider type in that county pursuant to subsection (g), an issuer shall cover out-of-network claims for covered health care services received from that provider type within that county at the in-network benefit level and shall retroactively adjudicate and reimburse beneficiaries to achieve that objective if their claims were processed at the out-of-network level contrary to this subsection. Nothing in this subsection shall be construed to supersede Section 356z.3a of the Illinois Insurance Code.

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed

in violation of this subsection may subject the issuer to a civil penalty of $5,000 per policy.

(k) For the Department to enforce any new or modified federal standard before the Department adopts the standard by rule, the Department must, no later than May 15 before the start of the plan year, give public notice to the affected health insurance issuers through a bulletin.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

(Text of Section from P.A. 103-656)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from

discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible

and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health

Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7),

"the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; ~~and~~

(CC) HIV; and~~.~~

(DD) Genetic Medicine and Genetic Counseling.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an

assessment of additional specialties to be included in the list under this subsection (c).

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate

access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where

the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

(Text of Section from P.A. 103-718)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access

to network-affiliated primary care, emergency services, and obstetrical and gynecological health care professionals.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers,

additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to

insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency

services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost-sharing provisions.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; ~~and~~

(CC) HIV; and~~.~~

(DD) Genetic Medicine and Genetic Counseling.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental,

emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not

have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10

business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to

ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

(Text of Section from P.A. 103-777)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the

patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary

has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the

Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers

for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; ~~and~~

(CC) HIV; and~~.~~

(DD) Genetic Medicine and Genetic Counseling.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(3) If the federal Centers for Medicare and Medicaid Services establishes minimum provider ratios for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and

Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

If the federal Centers for Medicare and Medicaid Services establishes appointment wait-time standards for qualified health plans, including stand-alone dental plans, in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for the same types of qualified health plans for that plan year. If the federal Centers for Medicare and Medicaid Services establishes time and distance standards for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of

subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment

for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental,

emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy

standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes a more stringent standard in any county than specified in paragraph (1) or (2) of this subsection (d-5) for qualified health plans in the type of exchange in use in this State for a given plan year, the federal standard shall apply in lieu of the standard in paragraph (1) or (2) of this subsection (d-5) for qualified health plans for that plan year.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios, time and distance standards, and appointment wait-time standards established under this Act or federal law may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and

the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

(Text of Section from P.A. 103-906)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances,

the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; ~~and~~

(CC) HIV; and~~.~~

(DD) Genetic Medicine and Genetic Counseling.

(1.5) Beginning January 1, 2026, every insurer shall demonstrate to the Director that each in-network hospital has at least one radiologist, pathologist, anesthesiologist, and emergency room physician as a preferred provider in a network plan. The Department may, by rule, require additional types of hospital-based medical specialists to be included as preferred providers in each in-network hospital in a network plan.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an

assessment of additional specialties to be included in the list under this subsection (c).

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate

access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of

mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where

the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)